

CANE & CRUTCHES STANDARD WRITTEN ORDER



Please fax to:
Anchorage (907) 274-0773
Fairbanks (907) 458-8914
Soldotna (907) 260-3757
Wasilla (907) 357-7883
or email to:
dme@procarehm.com

Patient Name, Address, Telephone & Insurance ID#:

Phone: _____ Ins ID#: _____

Patient DOB: _____ Sex: _____ (M/F)

Refer to Cane & Crutches coverage criteria sheet for all required documentation.

AMBULATORY AIDS:

Date of Last Visit: _____ Order Date: _____

Diagnosis and Code: _____

Length of Need (# of months) _____ 1-99 (99=lifetime) Patient Height: _____ in Weight: _____ lbs.

Standard Equipment

Cane, 700lb max (E0100)
Quad Cane, 500lb max (E0105)
Forearm Crutches, 500lb max (E0110)
Underarm (Auxiliary) Crutches, 650lb max (E0114)

Optional Equipment (Standard Equipment Only)

Ice Grips (A9999)

PROVIDER CERTIFICATION:

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

Provider's Signature _____ Date: _____ NPI: _____

Provider's Name: _____ Telephone: _____